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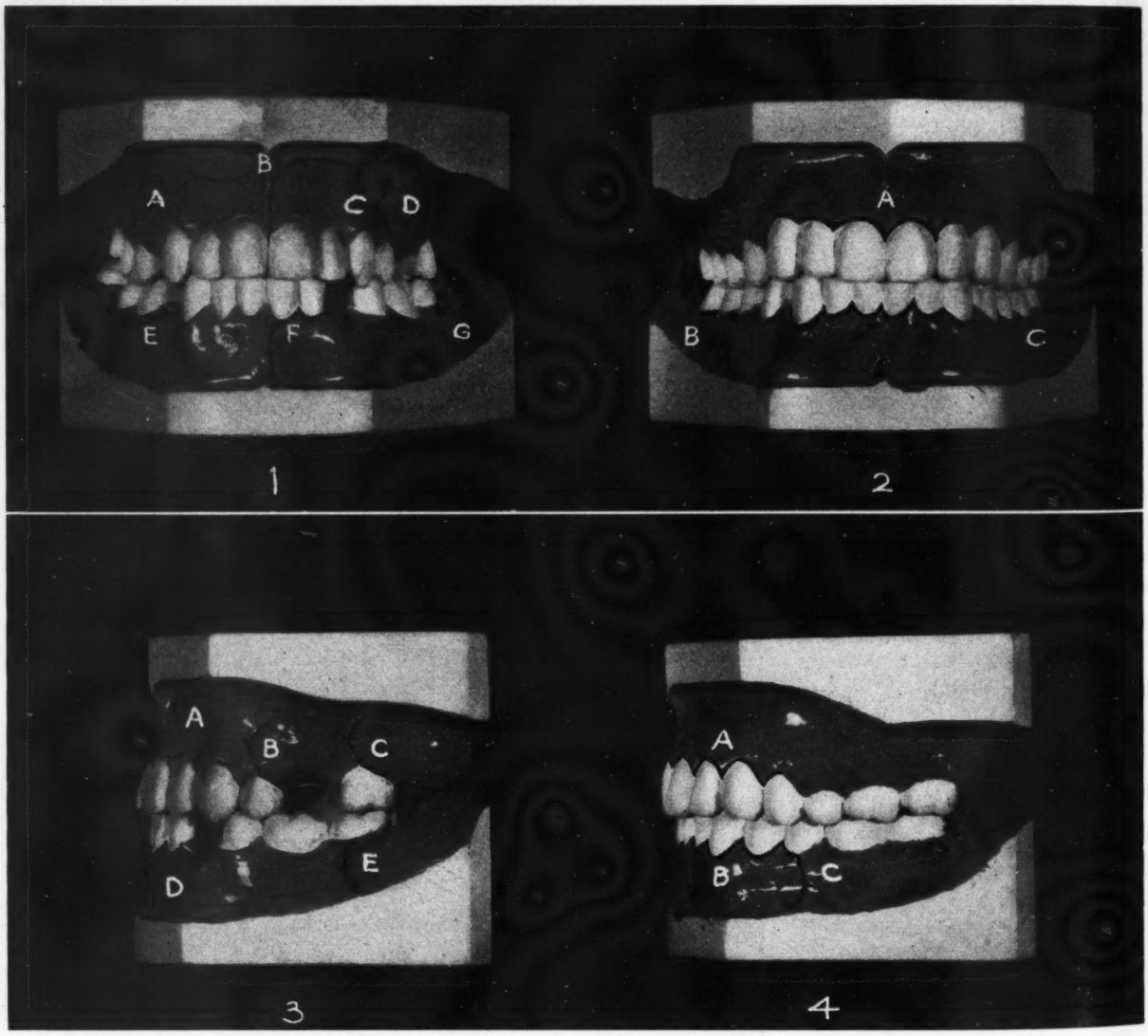
Dental Surgical Incisions

GEORGE A. MORGAN, D.D.S., Toronto, Ontario

MANY ARGUMENTS MAY be advanced for a more thorough preoperative examination in both a so-called simple extraction and in the more complicated types of extraction. Inadequate history of the systemic condition of the patient; neglect on the part of the operator to make full use of the preoperative dental roentgenogram, or a break in the technique of sterilization—all have been responsible for serious postoperative results in what had appeared to be a case of simple extraction. Successful postoperative results frequently depend as much on a knowledge of dental surgical incisions as on the method of operation.

Many authors have written on the importance of postoperative patient psychology, premedication, and the preparation of the field of operation. Excellent postoperative results are demonstrated both clinically and roentgenologically, but few papers have stressed the importance of the decision on the part of the dental surgeon as to when, where, and how to make the initial surgical step: the surgical incisions for the dental flap necessary in the removal of the more complicated dental conditions.



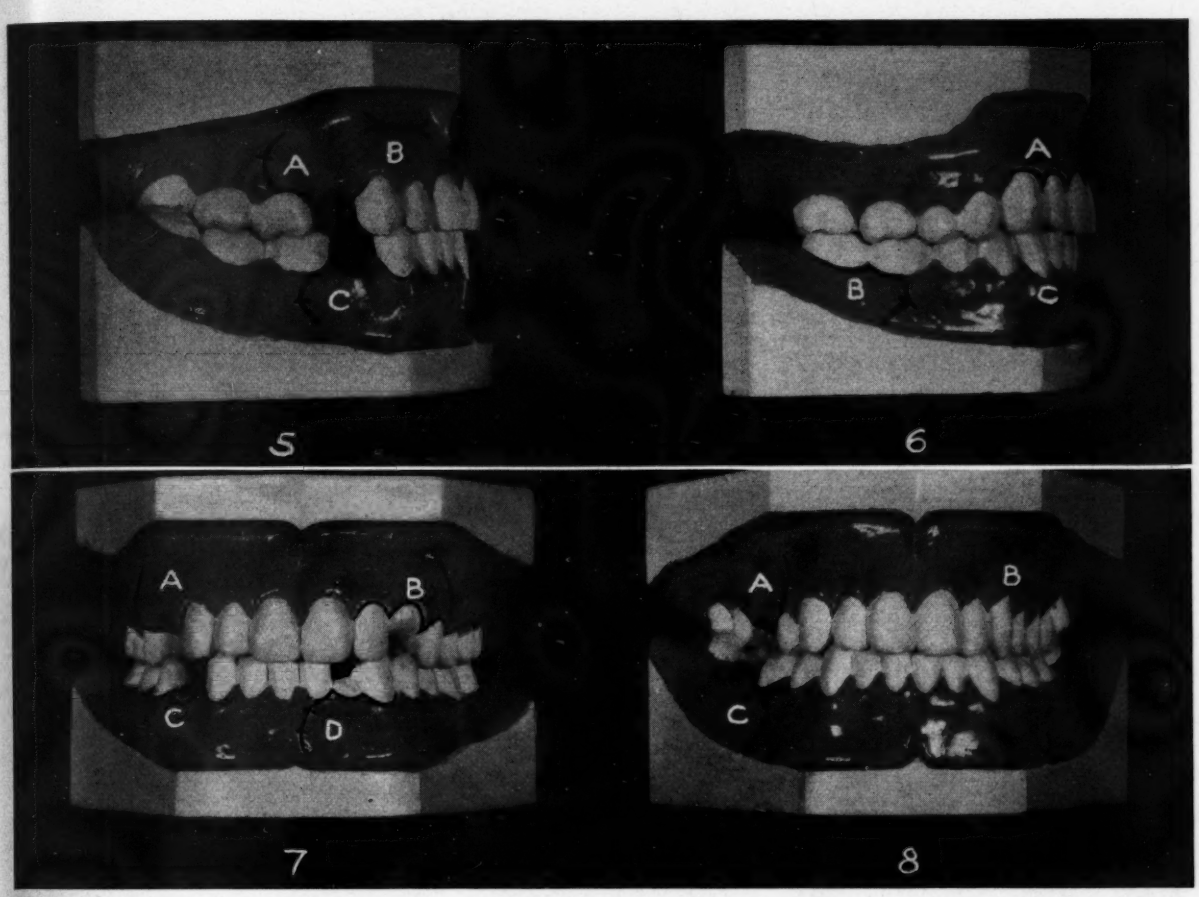


Fig. 1—A, Incision for the removal of a retained root, upper right first bicuspid area.
B, Types of incision for an apicoectomy of the upper anteriors.
C, Incision for the removal of a retained root, upper left second bicuspid area.
D, Incision for the removal of a retained root, upper left second molar area.
E, Incision for the removal of a retained root, lower right first bicuspid area.
F, Incision for the removal of a retained root, lower cuspid area.
G, Incision for the removal of a retained root, lower left third molar area, or impacted third molar.

Fig. 2—A, Type of flap recommended in the removal of anterior maxillary bone hyperplasias. A continuous incision should be made around the gingival border of the teeth and extended distally as far as necessary in order that the resection of the flap may expose to full view the area of bone to be removed. This type of flap has some advantages over the other types in that when sutured to place the blood supply is not interrupted and support is given to the organized blood clot, thereby confining the swelling to a minimum.
B, Incision for the removal of a hypercementosed lower right third molar.
C, Incision for the removal of a hypercementosed lower left second molar.

Fig. 3—A, Incision for an apicoectomy of the upper anteriors.
B, Incision for the removal of a hypercementosed upper left first molar.
C, Incision for the removal of a retained root, upper left third molar area, or an impacted third molar.
D, Incision suggested for the removal of a retained root, lower left cuspid area.
E, Incision for the removal of a retained root, lower left third molar area, or an impacted third molar.

Fig. 4—A, Incision for removal of cysts at upper anteriors.
B, Incision for the removal of cysts about the lower anteriors.
C, Incision for the removal of a hypercementosed lower left first bicuspid.

Fig. 5—A, Incision for the removal of a retained root, upper right bicuspid area.
B, Incision for an apicoectomy of the upper anteriors.
C, Incision for the removal of a retained root, lower right second bicuspid area.

Fig. 6—A, Incision for the removal of cysts about the upper anteriors. The same type of incision as that used for anterior maxillary bone hyperplasias.
B, Incision for the removal of a hypercementosed lower right second molar in a small mouth, or for an impacted third molar.
C, Incision for the removal of cysts or bone hyperplasias about the lower anteriors.

Fig. 7—A, Incision for the removal of a retained root, upper right first bicuspid area.
B, Incision for the removal of a carious upper left cuspid. The root of the cuspid is prominent and the underlying bone is thin. If an incision is made directly over the retained root, extensive bone destruction may occur. It is recommended that for the removal of an upper cuspid the incision be made well to the distal of the cuspid root and a suitable flap raised to give access for the removal of the necessary bone.
C, Incision suggested for the removal of a retained root, lower right first bicuspid area.
D, Incision for the removal of a carious lower left lateral.

Fig. 8—A, Incision for the removal of a retained root, upper right second bicuspid area.
B, Incision for the removal of a retained root, upper left third molar area, or an impacted third molar.
C, Incision for the removal of a retained root, lower right second molar area.

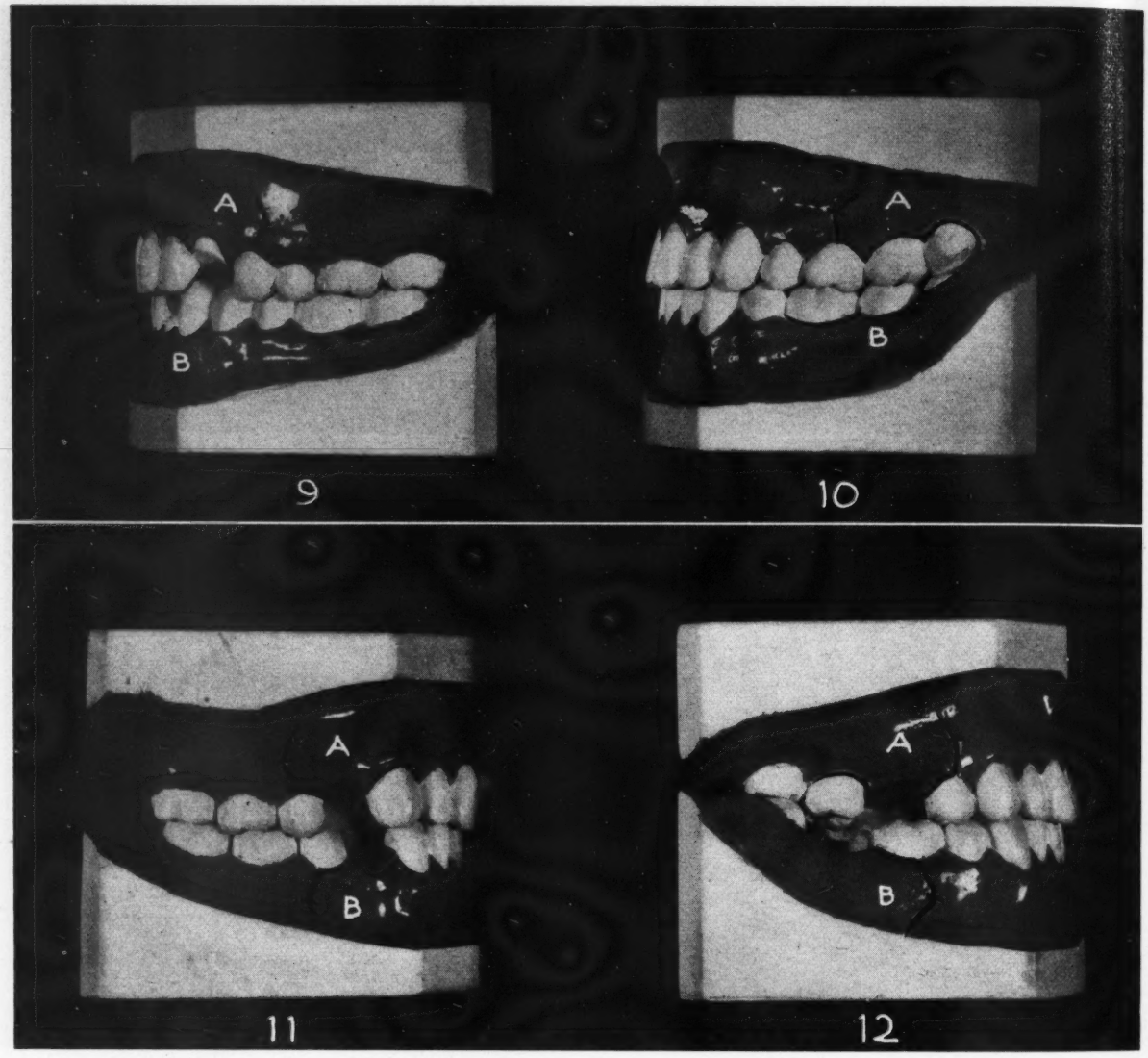


Fig. 9—A, Incision for the removal of a carious upper left cuspid.
B, Incision for the removal of a carious lower left lateral.

Fig. 10—A, Incision for the removal of a hypercementosed upper left third molar.
B, Incision for removal of suppressed lower left third molar.

Fig. 11—A, Incision for the removal of a retained root, upper right first bicuspid area.
B, Incision for the removal of a retained root, lower right first bicuspid area.

Fig. 12—A, Incision for the removal of a retained root, upper right first molar area.
B, Incision for the removal of a retained root, lower right second molar area.

Classification of Incisions

Dental surgical incisions may be classified in three groups: (1) those which are made on the labial, buccal, or lingual surface of the alveolus; (2) those which are made around the buccal or lingual-gingival margins of the teeth; (3) those which combine the first and second classifications to form the incision for an angular flap.

Technique

With satisfactory roentgenograms and an operative procedure outlined, dental surgical incisions and their resultant flaps, irrespective of their location, should be made with precision.

1. Care should be taken to evaluate the location of the approximate amount of bone to be removed in order that the flap when sutured will rest on a definite bone shoulder with a minimum amount of interference with blood circulation.

2. It is recommended that a double-ended knife, such as the Louie T. Austin knife, should be used. The incision should be made in such a way that the knife penetrates through the

(*Continued on page* 344)

A New Classification of Impacted Teeth

DONALD J. McDANIEL, D.D.S., Chicago

THE CLASSIFICATION OFFERED here enables the operator to visualize the degree of inclination mesially, distally, lingually, or buccally for all types of impactions. Knowledge relative to the depth of the impaction is reflected in the degree that the tooth is inclined. In deep or remotely placed impactions, the classification is given and then a statement about the location of other surrounding anatomic structure.

Generally speaking there are four directions by which to classify impacted teeth: (1) mesial, (2) distal, (3) lingual, and (4) buccal. For all practical purposes an impacted tooth may be said to be inclined in either one or two (but not more than two) of these four general directions, as follows: An impacted tooth may be inclined mesially. It may be inclined mesially and also possess an inclination either toward the buccal or the lingual. Likewise, a distal impaction may be inclined distally and also possess a lingual inclination; or it may be inclined distally and also possess an inclination toward the buccal. It may be easily understood, therefore, that an impacted tooth may be inclined either in one or in two of the four general directions.

When discussing an impaction, it is suggested that the mesial or distal inclination be mentioned first, and then, the lingual or buccal inclination. For example, one would say, "A lower left impacted third molar, inclined mesially 45 degrees, lingually 15 degrees." This accurate classification and brief terminology will give a definite image of the location of the impaction. The basis or starting point of this classification is as mathematically correct as carefully taken roentgenograms will permit.

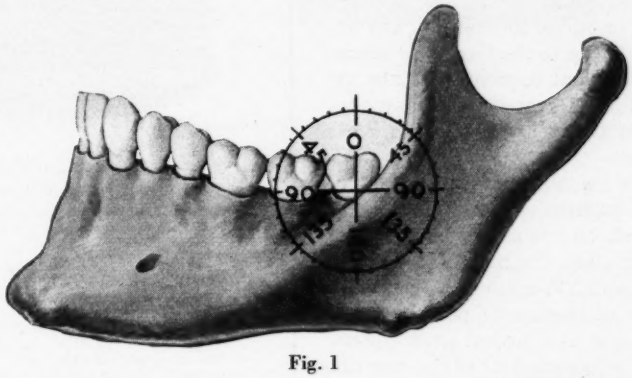


Fig. 1

Fig. 1—The vertical circle for lower impactions.

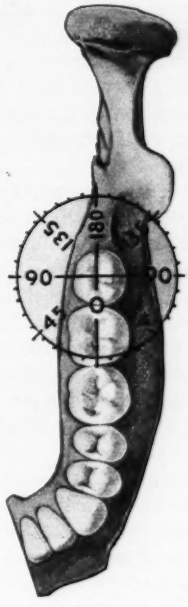


Fig. 2

Fig. 2—Horizontal circle for lower and upper impactions.

Classification Method for Lower Impactions

1. Two imaginary circles, on which are marked the degrees from 0 to 180 are located in the area of the impacted tooth to be classified (Figs. 1 and 2). These two circles form the basis of this classification for all impacted teeth.

2. The first circle imagined is the vertical circle (Fig. 1). The numbering of degrees on this circle begins with 0 at the top of the circle, and is numbered the same to 180 degrees in the two directions, mesial and distal. The position of 0 on this circle represents what would be the normal position of the crown of the tooth to be classified. Any deviation, either mesially or distally, from the point marked 0, may be indicated on the circle as so many degrees mesially or so many degrees distally.

3. The second circle to be consid-

ered is shown in Fig. 2, a circle placed in a flatwise or horizontal position. The numbering on this circle is similar to the numbering on the other circle except that the position 0 on the horizontal circle (Fig. 2) is now located at the normal mesial contact point of the tooth being classified. The 0 on this circle represents the normal position of the crown of the impacted tooth with respect to its lingual or buccal inclination. Any deviation either to the lingual or buccal from the point marked 0 may be indicated on this circle as so many degrees lingually or so many degrees buccally.

4. The combination of the two circles as outlined is shown in Fig. 3. The circle that is placed in a vertical position gives the mesial and distal inclinations. The circle placed in a flatwise or horizontal position gives the lingual and buccal inclinations. If the roentgenograms of the case are accurately taken, a definite mental interpretation may be given, so that when talking, reading, or writing about any specific case, it is possible to convey definite directions in degrees, mesially, distally, lingually, or buccally.

5. As already stated, the roentgenograms should be taken as accurately as possible from different angles in order to give the correct degree of inclination, mesially, distally, lingually, or buccally. The mesial and distal inclinations are obtained by the ordinary technique for intra-oral roentgenograms of the lower teeth. The lingual and buccal inclinations are obtained by having the patient close or bite on a regular dental film, negative side downward, and expose the film from below the angle of the mandible. This exposure, when accurately made, gives a definite angulation, either lingually or buccally.

Classification Method for Upper Impactions

1. The same plan of classification is used for the upper teeth, except that the marking of degrees on the vertical circle is changed so that the starting point, 0, is now at the bottom of the circle (Fig. 4). In other words, the marking of degrees on the vertical circle is reversed to correspond to the opposing position of the upper teeth in relation to the lower.

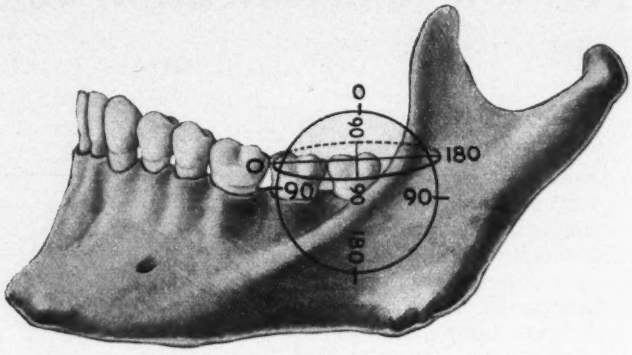


Fig. 3

Fig. 3—Appearance of the combination of the two imaginary circles.

Fig. 4—Vertical circle for upper impaction.

Fig. 5—Lower left impacted third molar, inclined mesially 90°. No lingual or buccal inclination.

Fig. 6 — Lower left impacted third molar, inclined mesially 45°, lingually 15°.

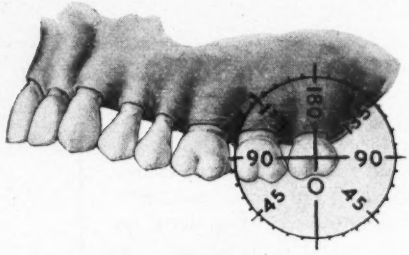


Fig. 4

Fig. 5

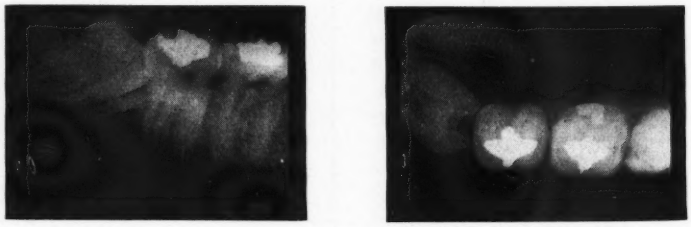


Fig. 6

2. The point 0 on the vertical circle (Fig. 4) represents the normal position of the crown of the upper tooth to be classified, and any deviation mesially or distally may be indicated by the marking on the circle. The lingual and buccal inclinations are indicated on Fig. 2 which serves for the lower teeth as well.

3. The mesial and distal inclinations for the upper teeth are obtained by the ordinary technique of intra-oral roentgenograms of the upper arch. The lingual and buccal inclina-

Fig. 7

Fig. 8

Fig. 9

Fig. 7—Upper left impacted second bicuspid, inclined distally 90°, lingually 10°.

Fig. 8—Impacted upper right cuspid, inclined mesially 45°, lingually 15°.

Fig. 9—Upper right impacted third molar, inclined distally 175°. No lingual or buccal inclination.

tions for the upper teeth are not so easily obtained with a roentgenogram as the same inclinations for the lower teeth; however, roentgenograms taken from different angles of the impacted upper teeth will show angulation and overlapping structure, and will furnish the desired information about the different degrees of inclination lingually or buccally.

4. In many cases, in addition to roentgenograms to indicate these inclinations, digital palpation may be used in order to obtain the degrees of inclination lingually or buccally. The alinement or malposition of the adjoining teeth, as observed clinically, is another valuable asset in determining the exact position of the impacted upper tooth.

5. As previously stated, if the tooth is deeply or remotely impacted, its classification may be given first, and then, its location relative to surrounding anatomic structure. In some of the cases shown in the accompanying illustrations, this rule could be applied.

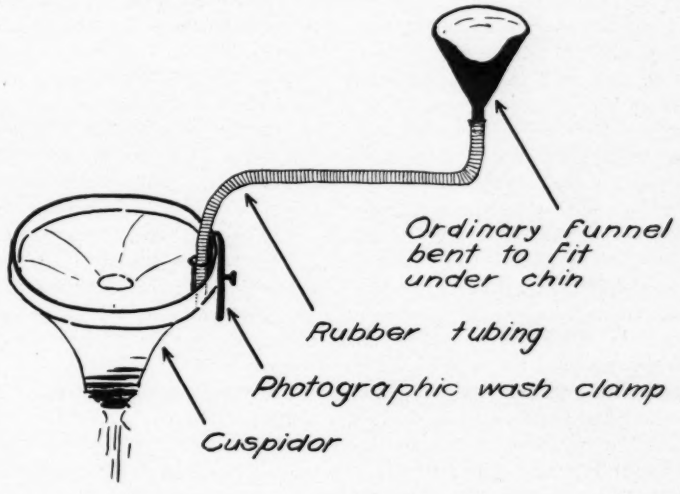
55 *East Washington Street.*

Clinical NOTE

Funnel Expectorator

DOCTOR MANUEL A. KLINGER, D.D.S., of Detroit suggests the use of a funnel as an auxiliary to the cuspidor. (See accompanying illustration.) The operator can wash the patient's mouth and have him expectorate into the funnel (held by the assistant) without very much movement on the patient's part. The saliva ejector can, of course, be used between washings. The funnel device should be particularly valuable in conjunction with an analgesia machine.

14149 *East Jefferson Avenue.*



The Optical System of Denture Construction

JAMES S. MILLER, D.D.S. Trenton, New Jersey

OWING TO THE INSERTION of the elevator muscles of the mandible between the temporomandibular articulation and dentures, the force exerted on the temporomandibular articulation and the tissues under the dentures when the masseter, temporal, and internal pterygoid muscles contract is almost equally distributed; however, because the articulation is cushioned with interarticular fibrocartilage and lubricated with synovial fluid, the shock is greatly minimized. The hard and soft tissues under the dentures, on the other hand, have no such protection, and are, therefore, subject to laceration and destruction, particularly when malocclusion is present; however, if there is balance between the upper and lower dentures in centric, protrusive and lateral movements of the mandible in harmony with the temporomandibular articulation, the pressure on the tissues under the dentures is equally distributed, and healthy stimulation of the tissues results. From the foregoing, it is readily seen how important it is to obtain perfect balance for occlusion and efficiency. Whenever there appears an inclination of a condyle in the function of the mandible, cusp teeth are indicated. The height of the cusps depends on the degree of inclination.

When the mandible moves from right to left and the center light[1] moves to the 35 degree line on the left side of the screen above the horizontal line, there is a 35 degree inclination on the right side of the mandible, and it will require a 35 degree cusp on the right side in the molar region to balance the dentures. It is true that after grinding the dentures to the inclination obtained from the patient, the cusps of the second molar on the right side will be somewhat less than 35 degrees; nevertheless, one must begin with 35 degrees to allow for grinding; the same applies to the left side. The removal of the natural teeth does not alter the anatomy of the anterior part of the glenoid fossa nor of the condyloid process of the mandible; they retain their shape which must be accommodated to the artificial teeth, and as previously stated, if the condyle moves on an inclined plane, the accommodation calls for cusp teeth, if occlusion is to be obtained and destruction prevented of hard and soft tissues under the dentures.

Because there was no exact means to ascertain the variety of forms of the fossa and the condyloid process, it does not follow that their importance in relation to occlusion must be ignored when a ray of light reveals their presence and shows their variety of forms. The first requisite, therefore, must be the exact registrations of the movements and positions of the condyle in the glenoid fossa. These movements in normal function are slight and are easily lost or misinterpreted.

Technique

The armamentarium needed is shown in Fig. 1.

1. Take a snap impression of the upper; scrape the hard portion of the palate; pour the model; make the baseplate; build up in compound sufficiently to mark the median line and lip line.

2. Attach the level to compound so that the median line is in the center of the long axis of the level (Fig. 2).

3. With a soft pencil, mark the position of the head of the condyle on the right side of the patient.

4. Take an impression; when the plaster is hard, measure the distance between the mark over the head of the condyle and the median line. (Transfer this distance to the examination card.)

5. Place the patient's head in a horizontal position (not tilted to any side) and set the level so that the bubbles are in the center, and lock the level firmly (Fig. 3).

6. Remove the impression and relieve the hard portion of the palate by scraping it slightly.

7. Take the lower impression in the usual way and send the two impressions to the laboratory, with two mounting plates (Fig. 1, A) and upper occlusal plate (Fig. 1, F). The distance between the mark over the condyle and the median line should be marked on paper in the instructions.

A. The technician in the laboratory will pour models in stone, attach a mounting plate to each model, and establish the median line and lip line on the model as shown in Fig. 4.

B. He will then level off the articulator on the bench and level off the upper model and impression in the articulator and establish the distance between the artificial condyle and the median line (Fig. 5).

C. The technician will remove the model from the articulator; separate the two impressions from the models,

Fig. 1—A, Mounting plates; B, clamp for eliminating bite; C, light; D, screen; E, lower occlusal plate; F, upper occlusal plate; G, level; H, spirit level; J, dividers.

Fig. 2—Baseplate built up with compound; median line and lip line marked, and spirit level attached. Ready for impression.

Fig. 3—Impression in mouth; head in horizontal position (not tilted to any side); level set so that the bubbles are in center and firmly locked, and distance between median line and position of condyle obtained by means of dividers.

Fig. 4—Model poured with mounting plate attached; median line and distance of lip line marked on model; ready to level off in articulator.

Fig. 5—Articulator leveled off on bench by means of level (Fig. 1, G). Spirit level, impression and model leveled off in articulator and distance between median line and artificial condyle established by means of dividers; the upper model is thus placed in exactly the same relation to the artificial condyles as the maxilla was to the natural condyle.

Fig. 6—Model plastered to the upper member of the articulator. Upper occlusal plate (Fig. 1, F) leveled off by means of level (Fig. 1, G) and attached to baseplate with compound.

Fig. 7—A mark is made on mentum with a soft pencil. Patient is instructed to swallow and when the lips are barely touching, the position is accepted as the rest position of the mandible. By means of dividers, this distance is measured between the mark on the mentum and the base of the nose. This establishes vertical relation of mandible to maxilla.

Fig. 8—Upper and lower occlusal plates in mouth and central-bearing point adjusted to vertical relation.

[1]Miller, J. S.: An Optical System for the Registration of Mandibular Movements by Means of Light, DENTAL DIGEST, 44:8 (January) 1938.

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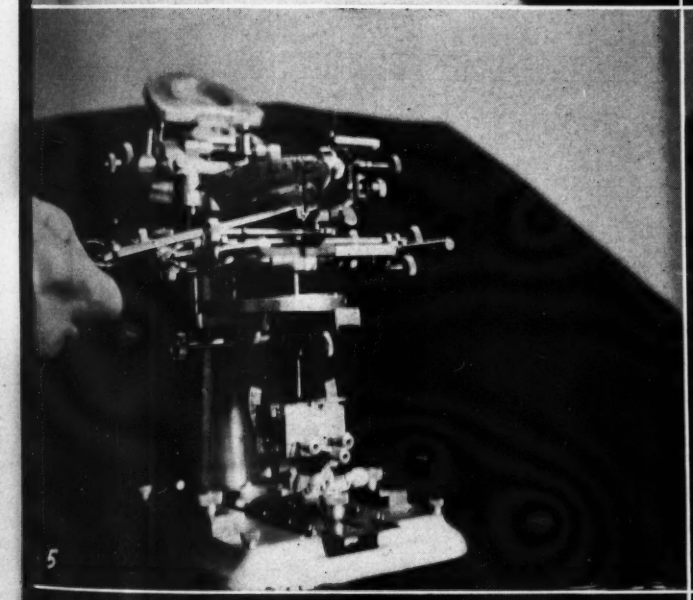
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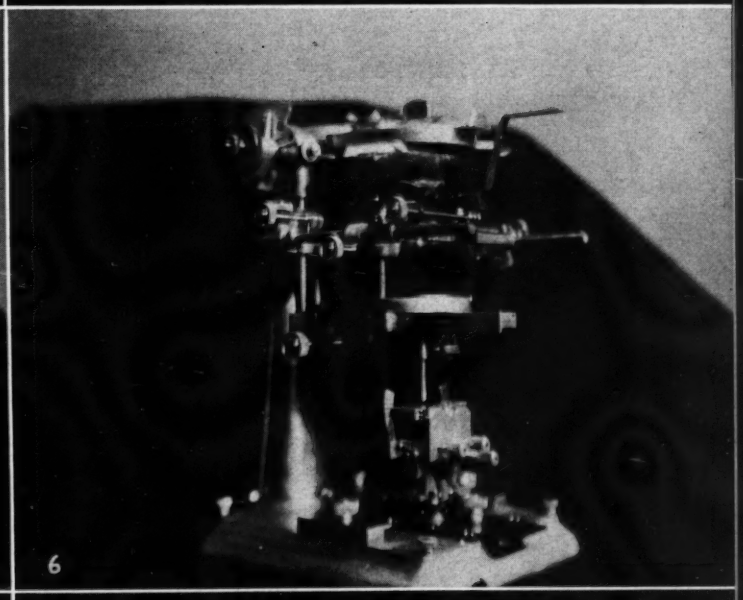
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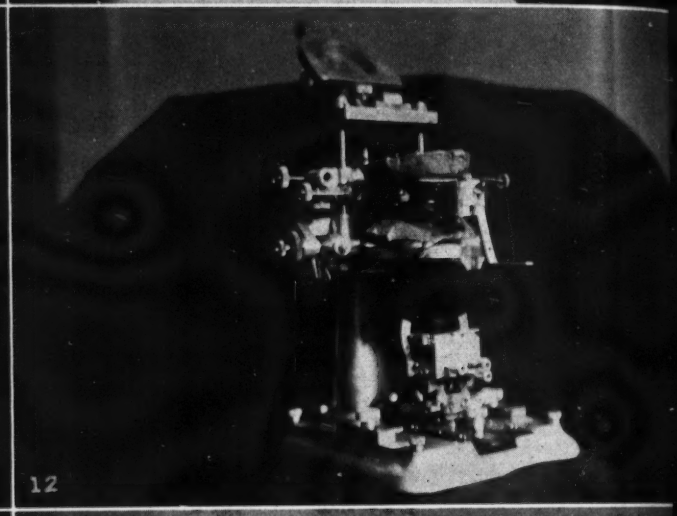

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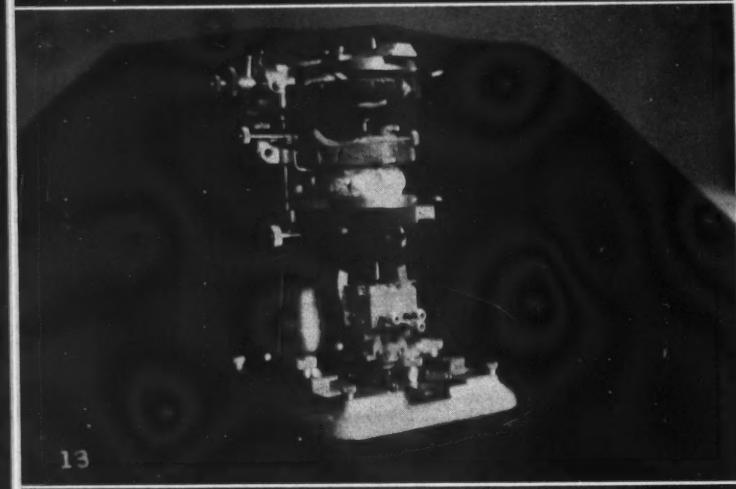

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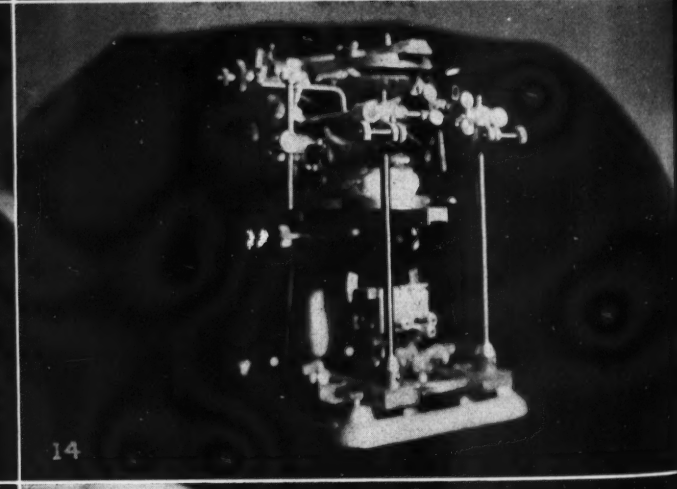

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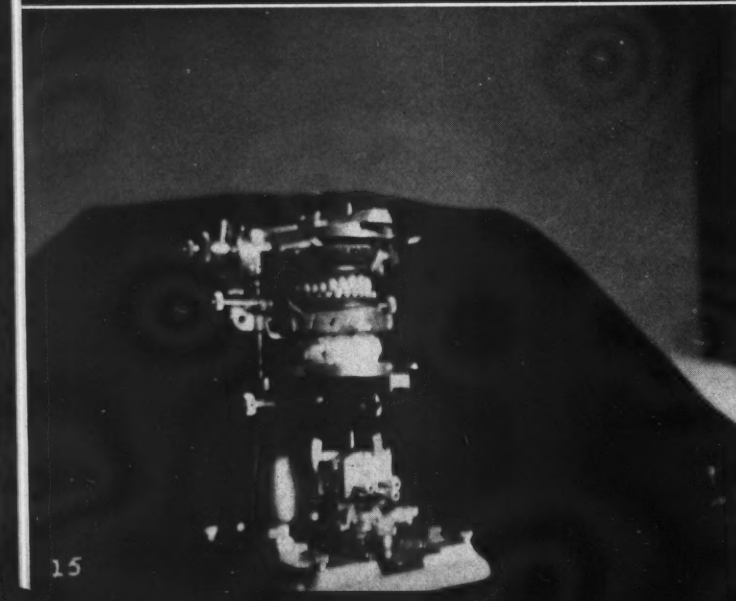

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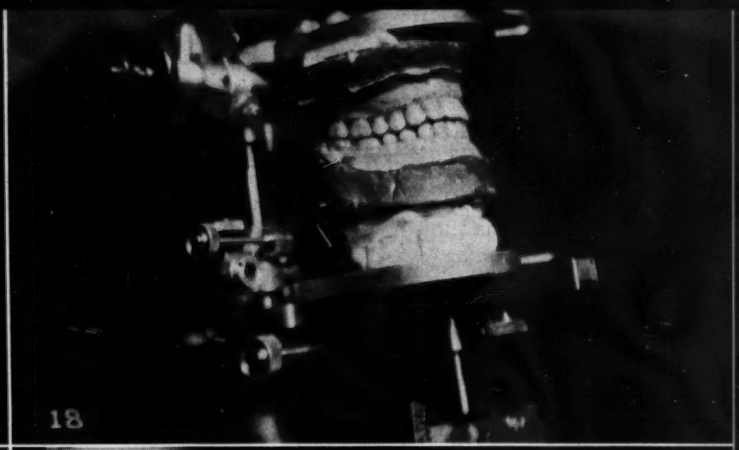

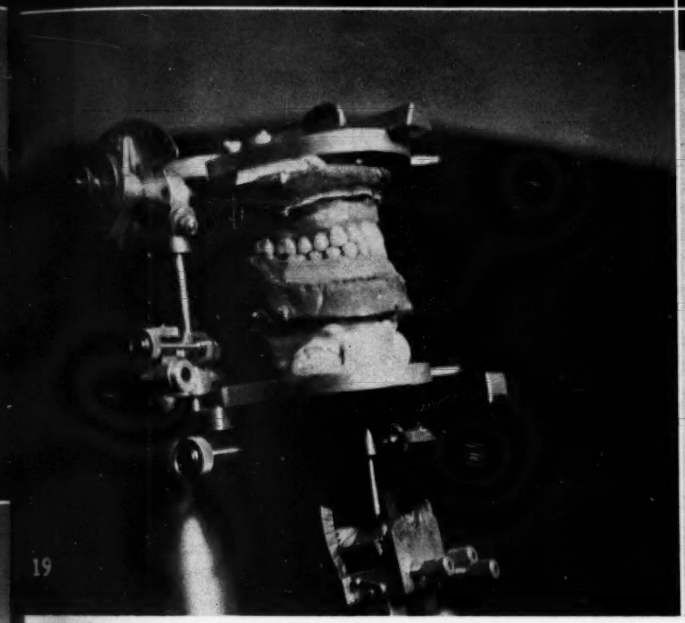

Fig. 9—Light attached to lower occlusal plate, screen to upper occlusal plate. Three lights centered on horizontal line with center light at junction of horizontal and vertical lines ready for registration of movements and positions of mandible as previously described.[1]

Fig. 10—Lights on screen in centric occlusion and clamp (Fig. 1, B) with plaster, embracing the upper and lower occlusal plates, thereby eliminating the bite.

Fig. 11—Upper and lower occlusal plates after removal from mouth, being held together firmly by means of clamp and plaster.

Fig. 12—Articulator inverted, upper and lower occlusal plates in position ready to plaster lower model to lower member of articulator.

Fig. 13—Articulator in its normal position ready for setting up teeth.

Fig. 14—Curve-former in position to establish curve of Spee in relation to artificial condyle inclination obtained from patient to which upper teeth are set. Curve-former is then removed and lower teeth set to upper.

Fig. 15—Teeth set up in harmony with inclination obtained from patient.

Fig. 16—Dentures in patient's mouth for try-in.

Fig. 17—Dentures, models with mounting plates attached, after vulcanization.

Fig. 18—Dentures in position in articulator. Photograph was taken to show imperfections no matter how carefully vulcanized.

Fig. 19—Same dentures after grinding to angles obtained from patient.

Fig. 20—Finished dentures in patient's mouth.

---

and make a baseplate for each model.

D. The upper model and baseplate will then be placed into the articulator and the upper occlusal plate will be leveled.

E. Next, a small roll of compound will be heated, attached to the upper baseplate and then to the upper occlusal plate (Fig. 6).

F. The baseplates are ready to be forwarded to the dentist after the models have been inserted in mineral oil for two hours to allow them to harden.

8. When the dentist receives the baseplates, he attaches the lower occlusal plate to the lower baseplate, parallel to the upper occlusal plate.

9. With a soft pencil, make a mark on the mentum; have the patient swallow, and when the lips are barely touching, measure with the dividers the distance between the mark on the mentum and base of the nose as shown in Fig. 7, thus establishing the vertical relation of the mandible to the maxilla.

10. Place the upper and lower occlusal plates in the mouth and manipulate the central-bearing point until the vertical relation is the same with the baseplates in the mouth (Fig. 8).

11. Attach a light to the lower occlusal plate; attach the screen to the upper occlusal plate and focus the three lights on the horizontal line, so that the center light is at the junction of the horizontal and vertical lines as

shown in Fig. 9. Register the movements and positions of the condyle in the glenoid fossa.[1]

12. When registration is completed and the three lights are on the horizontal line and the center light is at the junction of the horizontal and vertical lines (already accepted as centric occlusion), pour plaster in the clamp (Fig. 1, B) and place this over the extension of the upper and lower occlusal plates (Fig. 10). By this means centric occlusion is established and the so-called bite eliminated. It may be mentioned here that the central bearing point is locked, so that the patient cannot move the mandible while the plaster is setting. This lock is attached to the upper occlusal plate.

13. When the plaster is hard, remove the two occlusal plates from the mouth. Remove the light and screen; select the teeth and send the two upper and lower occlusal plates held together by the clamp as shown in Fig. 11 to the laboratory, together with a notation regarding the degree of inclination on the right and left sides of the condyle and any other instructions necessary.

A. The technician will invert the articulator; place the upper and lower baseplates in their proper positions (Fig. 12); plaster the lower model to the lower member of the articulator, and place the articulator back to its normal position (Fig. 13).

B. The saggital condyle path degree plates are then set by the technician according to the instructions: 35 degrees on right, 15 degrees on left.

C. The clamp (Fig. 1, B), holding the two occlusal plates, is removed; the light is attached to the lower occlusal plate, the screen to the upper. The center light is focused at the junction of the horizontal and vertical lines on the screen.

D. The lower member of the articulator is moved from right to left and the incisive pin is adjusted until the center light registers 35 degrees above the horizontal line on the left side of the screen.

E. The left wing of the incisive guide is then lowered until the light moves on the horizontal line; the cusp height is thus established for balance and efficiency. (If a higher cusp is desired in the bicuspid region the light may be brought down below the horizontal line in the same ratio as it has been raised above the line, namely, 35 degrees.)

F. The same applies to the left side of the articulator.

G. The curve-former is placed in position on the articulator (Fig. 14). (This instrument establishes the curve of Spee in harmony with whatever inclination the artificial condyle path is set.)

H. The upper teeth are set up to the established curve.

I. The curve-former is then removed from the articulator and the lower teeth are set to the upper (Fig. 15).

15. The dentures are then forwarded to the dentist for a try-in (Fig. 16).

16. The dentures are returned to the laboratory, and when vulcanization is completed, when models and teeth are cleaned (Fig. 17), they are replaced in the articulator (Fig. 18).

17. The dentures are then ground to the angles obtained from the patient (Fig. 19), finished, and returned to the dentist (Fig. 20).

Advantages

1. The ray of light gives graphic registration of three dimensional movement, enabling the dentist to study the movements and positions of the condyle in the glenoid fossa and distinguish clearly between centric occlusion and retrusion, an important point in denture construction.

2. The exact cusp height may be ascertained.

3. By the same ray of light, centric occlusion is established, the so-called bite thus being eliminated.

4. The spirit level (Fig. 1, H) and dividers (Fig. 1, J) make it possible to take the impression and transfer to the articulator in one operation. By the same dividers the vertical relation of the mandible to the maxilla is established.

5. The mounting plates enable the operator to remove models from the articulator, vulcanize, and place them back in exactly the same position in order to grind the teeth to the angles obtained from the patient for balance and efficiency.

6. A close examination of the articulator will reveal that it is a precision instrument in every respect and will fulfill all requirements in modern prosthodontia.

105 *West State Street.*

Dental Surgical Incisions

(*Continued from page* 336)

alveolar tissue and periosteum to the bone, so that when it is resected by means of a blunt instrument, the periosteum is peeled from the bone and not torn as is frequently the case.

3. On completion of the operation, the flap should be placed in its original position and sutured together, the edges being made to approximate by means of number 000 catgut suture material and a minimum amount of sutures.

4. Having first walled off the operative area with a sterile gauze sponge, the incision is made, the flap resected, and the field of operation exposed.

5. The flap is held in place by means of a Louie T. Austin tissue retractor.

6. It is suggested that in all conditions necessitating flaps in the anterior maxilla or mandible (lingual), the incision be extended distally along the lingual-gingival margins of the teeth, as far as necessary in order that the resection of the flap may expose to full view the operative area. The retained root most frequently found is that of the buccal root of the upper first bicuspid. When a flap is necessary for the removal of fractured bicuspid roots, an incision distally over the second bicuspid is suggested rather than one anteriorly over the cuspid.

All cross markings on incisions in the accompanying illustrations suggest suture points.

2 *Bloor Street, East.*

The Editor's Page

CHARLES NELSON JOHNSON

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to advance a young profession.

Palatine Margins for Dentures

E. ROLLIN STEALY, D.D.S., Shenandoah, Iowa

IN DENTURE CONSTRUCTION, the dentist is confronted with the problem of deciding on the most satisfactory termination of the palatine margin of the maxillary denture. If it is too long, it interferes with the movements of the soft palate; if it is too short, it often proves an irritant producing nausea. If there is a failure in soft tissue contact, the palatal seal will be broken and as a result the denture will not remain in position. Any of these defects is a discomfort to the patient and an annoyance to the dentist. In some cases it is more difficult to secure the proper palatal ending than in others.

In determining the length, or palatal ending, of a denture, there are several definite landmarks which must be considered before and after the impression is taken and a cast is made. Every denture should have its palatal margin resting on the immovable nonmuscular resilient tissue between the end of the hard palate and the movable tissue of the soft; the distance that the palatal margin of the denture should project on the soft tissue depends largely on the structure of the tissue as well as on the shape of the posterior palatine area of the oral chamber, the shape of the hard and the soft palates in particular. When the soft palatine curtain drops down abruptly (frequently in high vaults) at or near the end of the hard palate the width of the immovable resilient tissue is narrow; hence, the distance that the denture should extend on this soft tissue is limited, invariably less than 3 mm. When the soft palate is broad, terminating in a long, gentle slope, the resilient tissue has greater width, from 5 mm. to 8 mm. or more; hence, the denture may extend much farther backward without discomfort or dislodgement. The curvature of the average soft palate is between these extremes; hence, the average denture should extend from 3 mm. to 5 mm. on the soft palate.

In addition to the structure and curvature of the soft palate, there are other important landmarks to consider. The denture should not extend beyond the palatomaxillary depressions; invariably, it should extend beyond the margin of the hard palate. Another landmark is the soft tissues at the ends of the maxillary ridge. The heel of the denture should rest lightly upon this tissue, approximately 2 mm. or 3 mm. from the ends of the ridge. Some patients will tolerate considerable extension and

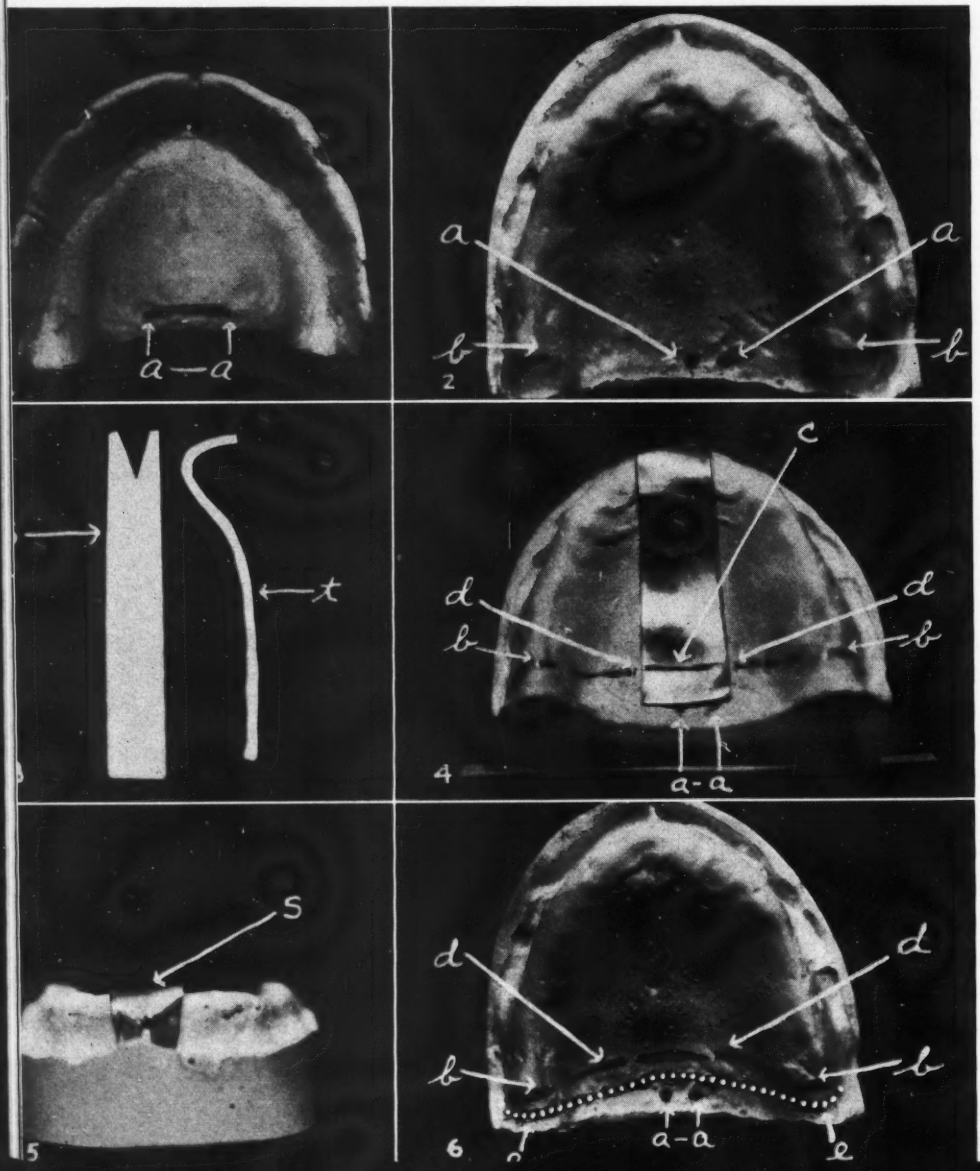


Fig. 1—A maxillary impression with the elevations representing the palatal "pits" (palatomaxillary depressions) connected with a groove because the elevations are faint.

Fig. 2—Palatal "pits" on impression (palatomaxillary depressions) indicated by a-a; b-b, ends of bone of maxillary ridge.

Fig. 3—Flexible strip (s) notched at one end for adaptation to cast on median line; t, side view of strip after adaptation to cast and removal.

Fig. 4—Metal strip (s) in position on cast with palatal end terminating at a-a (palatomaxillary depressions). End of hard palate also marked on cast by broken line b-d-d-b.

Fig. 5—Labial view of cast with metal strip (s) in position, its notched end being astride frenum elevation.

Fig. 6—Metal strip has been removed; line b-d-d-b indicates end of hard palate; a-a, representing the palatomaxillary depressions are visible; b-b, end of maxillary ridge; e-e, soft tissue at ends of maxillary ridge show where denture should end; continuous line from e to e shows where denture should end and beaded line be cut.

pressure upon the yielding soft tissue; others will not.

An ideal impression includes the soft tissues at the ends of the maxillary ridges, the distal margin of the hard palate, and the soft palate to and including the palatomaxillary depressions. If the impression does not include the areas described, another one should be taken. In some mouths the palatomaxillary depressions are faint; in others, pronounced. If they are faint and form almost invisible elevations on the impression, they may be connected on the impression with a shallow groove (Fig. 1, a-a), 1 mm. or 2 mm. in depth, or converted with a sharp instrument into pits on the impression.

Technique

1. When the impression is satisfactory, proceed in the following manner before boxing:

A. Trim the periphery so as to secure a close contact with the inner surface of the walls of the boxing mold when boxed.

B. Level the under surface of the impression through removing excess material.

C. Place it upon a flat surface and attach molding clay to its palatine border if needed to straighten or strengthen it.

D. Trim the distal surface of the impression, or clay if added, until it is at right angles with the surface upon which it rests, so as to secure a close contact with the adjacent surface of the walls of the boxing mold when boxed.

E. Place a separating fluid upon the impression, if needed.

2. Box and pour.

After the impression has been boxed, poured, and separated, the cast will have two well-defined pits (Fig. 2, a-a), or a ridge connecting the pits.

3. A strip of 20 gauge chamber metal, three eighths of an inch wide, or less if the vault is narrow, by 3½ inches long, with a notch at one end (Fig. 3, s) is placed upon the median line of the cast with the notched end astride the frenum of the lip elevation.

4. After carefully adapting the strip to the cast, cut the palatal end until it is flush with the impressions of the palatomaxillary depressions (Fig. 4, a-a). In Fig. 5 the notched end of the metal strip astride the frenum elevation is visible. In Fig. 3 is seen a side view of the molded metal strip. In case of emergency two strips of a hard base-plate sheet wax with a strip of .003 tin foil placed between them may be substituted.

5. Examine the palatal area of the oral cavity again carefully. Note the termination of the bone ends of the maxillary ridge and record these observations on the cast (Fig. 2, b-b) and also in the mouth with an indelible pencil. Relocate the end of the hard palate in the mouth, by digitation and also by having the patient say, "ah"; mark this location with an indelible line connecting the marks made on the ends of the maxillary ridge.

6. Remove the metal strip from the cast; place it in position upon the median line in the mouth, with a little denture powder for retention, if necessary. Make a transverse line across the strip at the junction of the indelibly marked end of the hard palate, with a lead pencil or a sharp instrument. Verify by having the patient say, "ah." Also check the end of the metal strip with the palatomaxillary depressions, and make corrections as necessary on the cast if there is a variation in location.

7. Transfer the metal strip from the mouth to the cast (Fig. 4); record on the cast the transverse line (Fig. 4, c), the record made when in the mouth, locating the end of the hard palate (Fig. 4, d-d).

If transferring of the records from the mouth to the cast has been done accurately, there will be marked on the cast the exact termination of the hard palate adjacent to the median line (d-d), the ends of the maxillary ridge (b-b), and the palatomaxillary depressions, a-a (Figs. 2 and 4).

8. Connect the points b-d and d-b with a broken line (Fig. 4), duplicating as closely as possible the indelible line previously made at the end of the hard palate. In Fig. 6 the metal strip has been removed and the broken line (b-d-d-b) is shown.

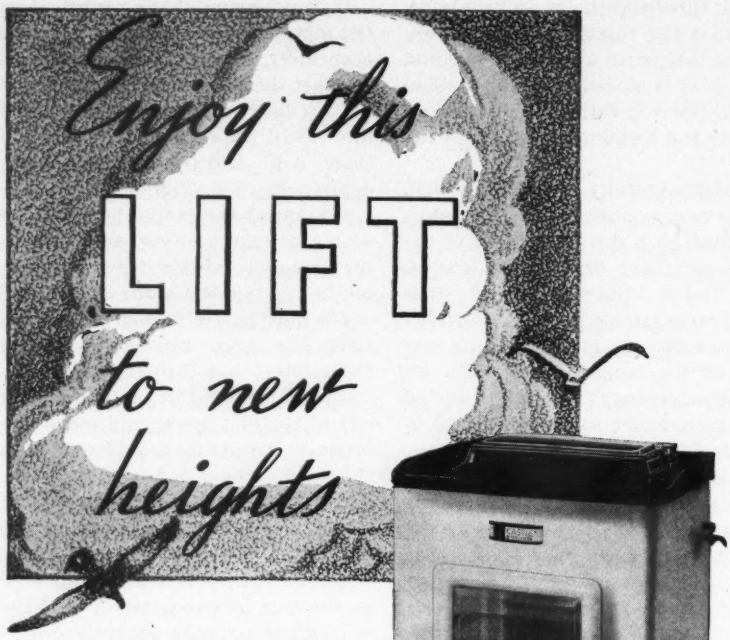
On the median line on the cast the end of the denture should terminate between the points a-a (Fig. 6) and the broken line b-d-d-b. In the maxillary ridge-end area, the points of termination should be from 2 mm. to 3 mm. from the ends of the ridge (Fig. 6, b-b) on the soft tissue, indicated on the cast by the letters e-e. If the soft palate extends abruptly downward at its junction with the hard palate, the end of the denture on the hard palate should be only a few millimeters from the hard palate; if the soft tissue has a long gentle slope, the denture in this area should end from 5 mm. to 8 mm. beyond the hard palate; if there is a medium slope, from 3 mm. to 5 mm.

9. After the location of the end of the denture is determined, connect the points e-e with a continuous line (Fig. 6, e-e). Use a number 8 or 10 round bur to cut a beaded line 1 mm. deep across the cast on the line e-e.

10. If this line is 5 mm. or more from the end of the hard palate (Fig. 6, b-d-d-b), cut another beaded line between the lines b-d-d-b and e-e.

11. If the denture proves to be too long, a portion of it can be removed without destroying the suction.

If the dentist sends the denture to a laboratory, when the trial dentures are returned for a recheck, he should cut the beaded line where needed, or instruct the laboratory to do so.



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THE DENTAL DIGEST

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NOTES ON THE *Cuff*

Sunday, July 17: Off to Washington with *Peter Swanish*, Commissioner of Unemployment Compensation in the State of Illinois to attend the National Health Conference called by the President. Visits on the train with *Fred Hoehler*, Director, American Public Welfare Association; *Robert E. Neff*, Administrator, University of Iowa Hospitals, and President, American Hospital Association; and *C. Rufus Rorem*, Director, Committee on Hospital Service, American Hospital Association.

Monday, July 18: A quick visit with *William Green*, President of the American Federation of Labor, as he sits at the counter in the Hamilton Hotel eating his coffee and rolls. At the Mayflower Hotel the setting for the National Health Conference looks like preparation for a disarmament conference or a peace conference. There are assembled representatives of all the groups interested in the problems of medical care. The tables, covered with green felt, are arranged in a horseshoe shape; the crystal chandeliers and the gilt decorations might make one think of Versailles, The Hague, or Geneva. The Conference is as important as one called for the maintenance of peace. It is to discuss the welfare of the American nation. A clock moves toward eleven. The photographers push one another and explode flash bulbs. The CBS announcer stands with stop-watch in hand. At eleven sharp *Miss Josephine Roche*, grey and gracious, Chairman of the Conference, is introduced and goes on the air. She reads the President's greeting which is built around the theme: "When we see what should be done and is not done," we should stop and take stock of ourselves and plan a course of action. *Miss Roche*, in her own talk, points out that human conservation is the function of government and that the "health denials and health needs" of the people must be met by the govern-

(*Continued on page* 350)

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ment. She points out that death comes high for the unskilled and that among the 50 million Americans in families with an annual income of less than $1000 there are serious "health denials" that must be recognized. In any plan, *Miss Roche* insists, the greatest opportunities must be preserved between those giving and those receiving the services.

Then the vigorous *Thomas Parran,* Surgeon General, United States Public Health Service, with characteristic directness and sincerity sounds the keynote that there must be equal opportunities for health for all Americans.

Irving Abell, President of the American Medical Association, rises to repeat the perpetual theme song of the American Medical Association: that the government should not intrude itself into the subject of medical care; that any centralized plan is doomed to failure; that what the American people need more than anything is a high standard of living and that their medical problems will then take care of themselves. This speech is not received with enthusiasm by the Conference.

Afternoon: Four representatives of labor and farm groups are heard: *William Green,* President, A. F. of L.; *Mrs. Dorothy J. Bellanca,* Vice President, Amalgamated Clothing Workers of America; *Benjamin W. Kilgore,* Executive Secretary, Kentucky Farm Bureau; *Mrs. H. W. Ahart,* President, The Associated Women of the American Farm Bureau Federation. Each tells the same story in slightly different fashion: that the people whom they represent have, in the words of *Miss Roche,* major "health denials and health needs" which have not been met under the present distributive system. Now is the time, all these spokesmen say, that the government must act. These representatives, we must bear in mind, are the voices of other millions of Americans.

Toward the end of the afternoon, a bald stiff-shouldered old man, one of the Boston Cabots, rises to speak: Mellow, deep of understanding, and rich in culture, *Hugh Cabot,* Consulting Surgeon at the Mayo Clinic, addresses himself to the Conference. His voice is sympathetic to the labor and farm groups; he is for doing something about the health needs of the American people. He says that

(*Continued on page* 352)

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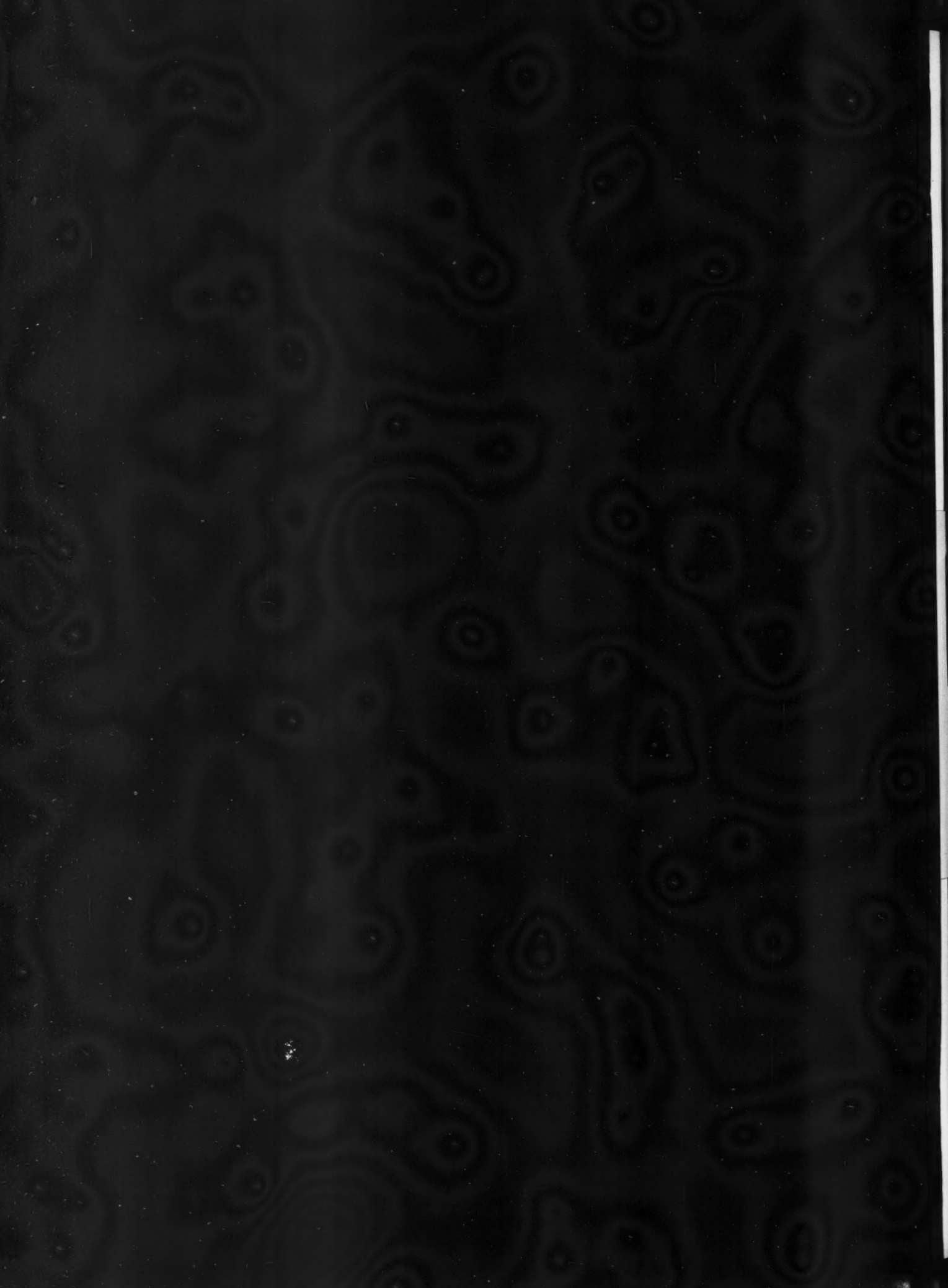

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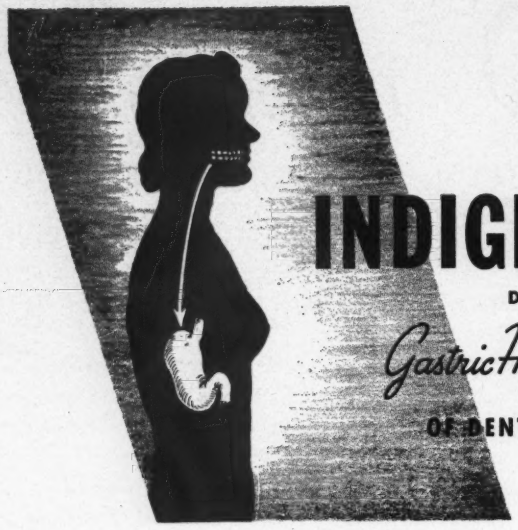

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the medical profession is "doing nothing and doing it skilfully." Furthermore, *Doctor Cabot* says that he can see nothing unprofessional, nothing unAmerican in turning the persons face-to-face (those who give and those who receive medical care) who have long been standing back-to-back. This time, says *Doctor Cabot,* the voice of the consumer is being raised for the first time; the people who should be most interested in medical care, those who receive it, have finally become articulate. Heavy and spontaneous applause marks the end of *Doctor Cabot's* speech, an applause in which *Doctors Abell, West,* and *Fishbein* of the American Medical Association do not participate.

In the discussions that follow these speeches, *Arthur McCormack,* Commissioner State Department of Health, Kentucky, and President, American Public Health Association, points out that this Conference represents the American people coming into the offices of American physicians and making a complaint. The diagnosis must be made by separate communities; the prescription cannot be of a national kind. He follows the pattern set down by the American Medical Association and pleads for more delay and more survey. Then rises *Mrs. J. K. Pettengill,* President, National Congress of Parents and Teachers, who says that there has been too much delay, that the research days are over, and that because children have a habit of growing up fast, valuable time cannot be lost in setting up a health program. *Mrs. Pettengill* remarks that some day someone will write a thesis on, "How Previous Researches in This Field Can Be Put to Work." And a Benjamin Franklin touch is added by *Hugh Cabot* who says that "facts like fish do not keep."

Olin West, Secretary of the American Medical Association, in anger comments on *Hugh Cabot's* speech: "The medical profession," he says, "is no more proud of him than he is of it." A chill greets this unfortunate remark and the American Medical Association definitely loses ground by it. It will not soon be forgotten.

Tuesday morning: The President of the American Medical Association is recognized by the chair. It appears that he is trying to win back some of the sentiment lost by *Doctor West's* speech the day before. He offers the facilities of the entire American Medical Association to the government committee. *Miss Roche* thanks him.

A voice that sounds like the voice of Herbert Hoover comes in over the loud speaker. It is *Edward S. Godfrey, Jr.,* Commissioner, State Department of Health, New York, insisting that all plans must be integrated with existing public health agencies and that all the government health agencies should be coordinated under a national department of health with a cabinet officer at the head of this department. The point of view is apparently well received by the Conference.

Walter Polakov, Ph.D., Director of Engineering Department, spokesman for John L. Lewis and the United Mine Workers of America, limps to the platform. He wears a bush jacket, and one is reminded of the people that the physician-author of THE CITADEL describes when *Polakov* damns the company doctors who supply a "bastard" kind of medical care for which the miner pays $1.50 by compulsory check-off from his pay. No venereal nor dental services are

included. The company doctor that he paints is incompetent, unsympathetic, almost inhuman. The miners, says their spokesman, need every kind of treatment except psychoanalysis and that, says *Mr. Polakov*, should be given to the coal operators and their superintendents.

So far no one has spoken for dentistry. Now *C. Willard Camalier*, President of the American Dental Association speaks to say that slight mention has been made during this Conference of the most prevalent disease known to man, namely, dental caries. He repeats the emphasis that the American Dental Association has given to dental health for American youth. He stresses the importance of a long-time preventive program for children. Although *Doctor Camalier's* program is not specific in detail, it is certainly more liberal and more realistic than any of the utterances made by the spokesmen for the American Medical Association.

A woman physician, *Ellen Potter*, Director of Medicine, New Jersey State Department of Institutions and Agencies, recalls the battle to get the Sheppard-Towner Act passed some years ago. She observes that the first million for a public health program, like the first million that one may earn, is the hardest to get.

Apparently during the sessions there have been some whispering campaigns going on, one of which was directed against *Mrs. H. W. Ahart*, President, The Associated Women of the American Farm Bureau Federation. She protests that the most ubiquitous spokesman for the American Medical Association has said that she is in the employ of some organization that is attempting to foster socialized medicine. *Mrs. Ahart* says that she is in the employ of no one and that she receives money from no one except her husband, a sheep raiser in California. She asks that this spokesman for the A. M. A. make a public apology, but there is nothing forthcoming from the A. M. A. representative except a smile; he makes no denial nor apology.

Louis Dublin, Ph.D., Statistician and Vice President, Metropolitan Life Insurance Company, exhorts the Conference to have no fears and to be bold and courageous in speaking in terms of hundreds of millions for a health program. He anticipates the opposition that such an extensive program will initiate from the reactionaries, but he says, "There is no greater investment that a government can make than for the preservation of the health of its people."

Robert E. Neff, Administrator, University of Iowa Hospitals; President, American Hospital Association, addresses the Conference: Private philanthropy is no longer forthcoming in the same degree as in the past; it is necessary to get help from public spending agencies to keep the hospitals of the country functioning efficiently. He makes plain that free care is always a myth; that someone must always pay for it, whether it is the person himself, his family, the government, industry, or philanthropy.

James E. Paullin, Professor of Clinical Medicine, Emory University School of Medicine, tells the Conference that in Georgia it was the medical association that directed the attention of the public to the problems of medical indigents, and not the social worker who discovered the situation. He describes the Georgia medical plan which seems to work satis-

(*Continued on page* 354)

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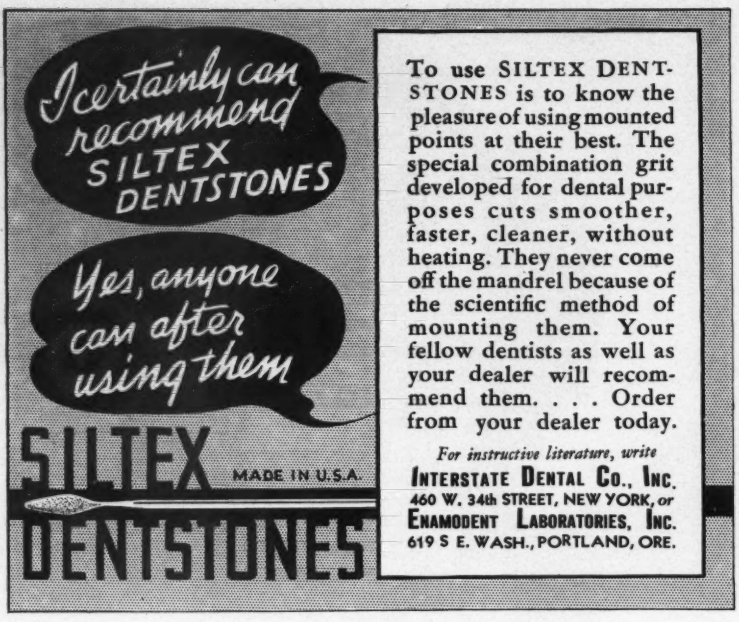
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factorily. This is organized and controlled by the medical association. *Paullin* does not mention, however, the excellent dental plan in the state of Georgia and the excellent dental division in the health department of that state.

A young woman who is later in the session characterized as "a mere slip of a girl" addresses the Conference as a representative of the wives of steel workers: "Life," says she, "is not so important to industry as the speed-up and increased production." She reads case histories describing the health hazards of industrial workers. These reports are dramatic and, although not precisely scientific evidence, are received with intense interest by the Conference; or perhaps the interest is due to the clear, young, sincere voice of *Miss Florence Greenberg,* Educational and Legislative Chairman, Council of Auxiliaries, Steel Workers Organizing Committee.

Following this representative of labor is a representative of industry, *Charles W. Taussig,* Chairman, Advisory Committee, National Youth Administration, and President of the American Molasses Company. Anyone who might have expected *Mr. Taussig* to give a Liberty League or United States Chamber of Commerce speech suffered disappointment. *Mr. Taussig* is of the opinion that the 850 million dollars suggested for the National Health Program does not frighten business. It should be regarded, he says, as a subsidiary to industry, and not as a burden. He expresses the view that democracy is not a changeless economic order and that democracy should be a "sword as well as a shield, used to make new conquests as well as to defend old ones."

The Chairman of the Board of Directors of the National Association for the Advancement of Colored People, *Louis T. Wright,* M.D., accuses organized medicine of ignoring the health needs of the Negro. During the entire conference, no one refutes this assumption. Then another Negro representative, *George W. Bowles,* President-Elect, National Medical Association, describes the plight of his people—12 million of them and only 4,000 Negro physicians to care for their health needs. Nine million of these people live in the south and there are only 200 public health nurses to care for them and help them conquer ignorance and unsanitary living conditions. He recommends that the number of nurses be increased to 1500 for the south alone.

Sigismund S. Goldwater, M.D., Commissioner, Department of Hospitals, New York city, calls attention to large unknown factors in medicine that cannot be conquered by money grants or administrative methods; knowledge as well as great sums of money, new discoveries, new inventions are needed as much as money in the conquest of disease.

Miss Harriet Silverman, Executive Secretary, People's National Health Committee, Workers Alliance, brought the Conference to attention by her observation that more women have died of childbirth in the United States than the number of men who have died in all our wars. She predicted that if the administration would make the health of the people the next great objective, the people would respond as promptly as they have to other major measures of the Roosevelt administration.

Called to the rostrum is *Adolph Meyer,* Director, Psychiatric Clinic, Johns Hopkins Hospital. This venerable professor of neuropsychiatry knows the limitations of the human personality. He sees a danger in the magnitude, in the impersonality of this gigantic undertaking. He pleads that in any system the patient as a person should never be allowed to become a number on a card or an entry in a book. The medical needy may be at the top of the economic heap as well as at the bottom. Although health education is needed for the

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people in the slums, it is also needed for the people in the upper economic brackets.

C. Rufus Rorem, Ph.D. Director, Committee on Hospital Service, American Hospital Association, in a direct, crisp, factual talk showed the development of voluntary hospital plans. In these group insurance plans two years ago there were one-half million people enrolled; now there are more than 2 million. These groups operate on the group payment principle for which the patient receives semi-private accommodations in a hospital. From twelve to twenty-four dollars per family per year is paid for this service. These are not private promotional schemes; they are not stock or mutual insurance companies, but voluntary organizations that operate for the public welfare. Employed people subscribe to this plan and the development of these groups is greatest in the large cities, although the movement is spreading out through the country.

The author of the Model Health Insurance Bill, *Abraham Epstein,* observes that the American Medical Association has been using the same arguments against health insurance for twenty years. He points out that a health insurance system must be compulsory and that it should include all persons who earn less than $5,000 dollars a year. The cost of health insurance would be 5 per cent tax on wages; 2 per cent would be payable by the government and the other 3 per cent by employers and employees. For those persons earning more than $40 a week the employee would pay more than the employer; for those earning less than $40 per week the employer would pay the major percentage. He also insists that medical benefits should include the entire family.

Paul Kellogg, Editor, *Survey Graphic,* regards this next epoch as one in which the rank and file of Americans can do something about their health. To answer the representatives of the American Medical Association who fear government intrusion, *Mr. Kellogg* coined the epigram: "Better to lean on the broad shoulders of Uncle Sam than on the cadaverous shoulders of the Elizabethan Poor Laws.

Wednesday morning: July 20: The whisperers must have been saying during the night that the Committee

(*Continued on page* 356)

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on Physicians who were to meet in New York after this Conference were planning secession from the American Medical Association. One of their number, *Robert Osgood,* Professor Emeritus, Harvard University School of Medicine, emphatically states that no revolt nor any other medical organization is contemplated.

The President of the Executive Committee, American Public Welfare Association, and Director of the State Department of Social Security, Washington, *Charles F. Ernst,* warns that too much hope should not be raised in the hearts of the people who need the help. It would be calamitous to promise the people a solution of all their health problems.

The suggestions made by the Presidents of the American College of Surgeons and the American College of Physicians could hardly be called momentous. *Frederic A. Besley,* President of the American College of Surgeons remarked extraneously regarding the traffic toll from automobile accidents and suggested that a governor be placed over automobile motors. Whether *Doctor Besley* was speaking symbolically or not could not be determined. He might have meant that a governor should be placed on government spending, but it was not plain. *Doctor William J. Kerr,* Physician-in-Chief, University of California Hospital and President of the American College of Physicians made the about-face suggestion that a family doctor book be prepared by the United States Public Health Service and distributed to all families in the nation. The impression has always been that physicians are opposed to self-medication, even under the aegis of the United States Public Health Service.

Kingsley Roberts, Medical Director, Bureau of Cooperative Medicine, indicates the inconsistency in some of the attitudes of the American Medical Association. The Association, he says, is neither for government activities nor does it appear interested in voluntary health agencies. Group practice plans and prepayment plans had been constantly attacked by medical organizations. This speaker emphasizes that voluntary health agencies are more democratic than paternalistic government undertakings.

Morris Fishbein, Editor, *Journal of the American Medical Association,* believes that it is contradictory to the American spirit to plan a future wherein 40 million people had to be given medical aid by the government. He is of the opinion that medical care is not the most important problem before the American people. This seems to be a direct reversal of all the educational activities of organized medicine which through the years has attempted to show how important medical care is and that it should occupy a prominent place in the economic scale of consumption. *Doctor Fishbein* is fearful that existing agencies, such as privately endowed hospitals, fraternal organizations, lodges, insurance companies, would be dislocated under a national medical program of 850 million dollars.

The same note is sounded by the *Reverend Alphonse M. Schwitalla,* Editor, *Hospital Progress* who challenges the theory of medical equilization and the assumption that indigents should be wards of government rather than of society. He, too, believes that there must be safeguards erected to protect voluntary and private institutions.

General Counsel, American Federation of Labor, *Joseph A. Padway* expresses the satisfaction of organized labor with the functioning of the So-

cial Security Board and says that the medical plan being contemplated should be administered by that Board. *Mr. Padway* emphasizes that all voluntary insurance systems fail and gives as an example that only 25 per cent of the automobiles are insured under the voluntary insurance system. He looks back twenty-five years to the objection of organized medicine to the Workmen's Compensation Act which proved to be unfounded because both the patient and the physician profit under this law. Certainly medicine should not have a plan forced upon it; neither should medicine sulk, *Mr. Padway* feels, or sabotage a plan that would be put in operation.

Dexter Masters, Editor, *Consumers Union Reports* predicts that public demand and public support will be crystallized as a result of this meeting, and exhorts representatives to return home and translate the proposals at this Conference into legislation.

John Punnett Peters, Professor of Medicine, Yale University School of Medicine, remarks that the quality of care could never be determined by the method of payment.

A representative of the fraternal societies and International Workers Alliance, suggests that the WPA project be undertaken to study the positions of the fraternal societies. This speaker believes that the lodges throughout the United States, many of which are made up of the kind of people who would be benefited under this extensive health system, should be used as educational loci to create interest in the undertaking.

Miss Edith M. Gates, speaking for the Y. W. C. A., says that 86 per cent of apparently normal girls have physical defects, and that the girls for whom she speaks, the self-supporting, low-wage group, were particularly in need of low-cost health programs.

Clifford Grulee, Clinical Professor of Pediatrics, Rush Medical College, University of Chicago, describes the impressiveness of this project by saying that he felt as if someone had handed him a 2 pound premature infant and a check for a million dollars with the instruction to develop a 200 pound heavyweight champion within a year. *C. E.-A. Winslow,* Professor of Public Health, Yale University, School of Medicine, retorts that he

(*Continued on page* 360)

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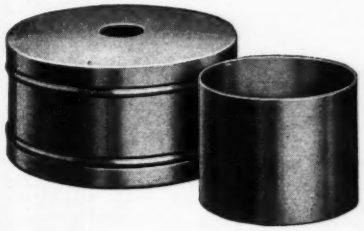

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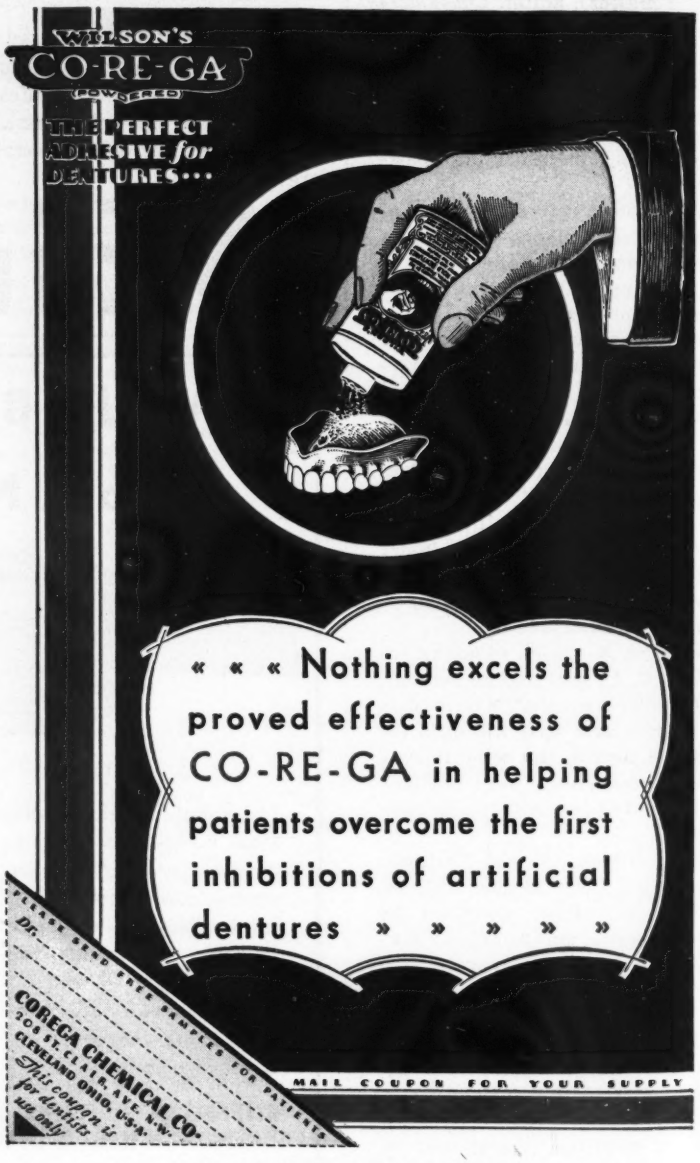
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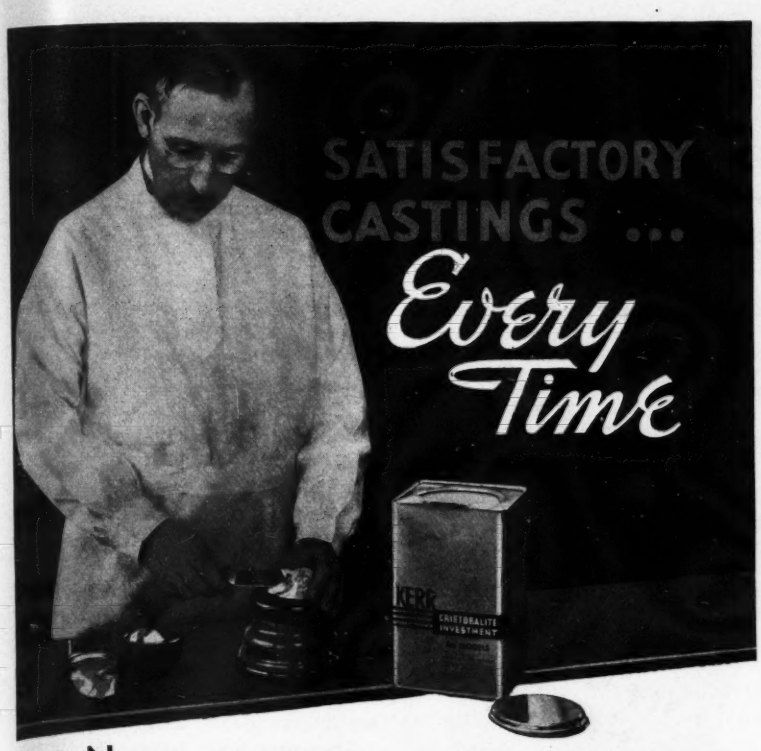

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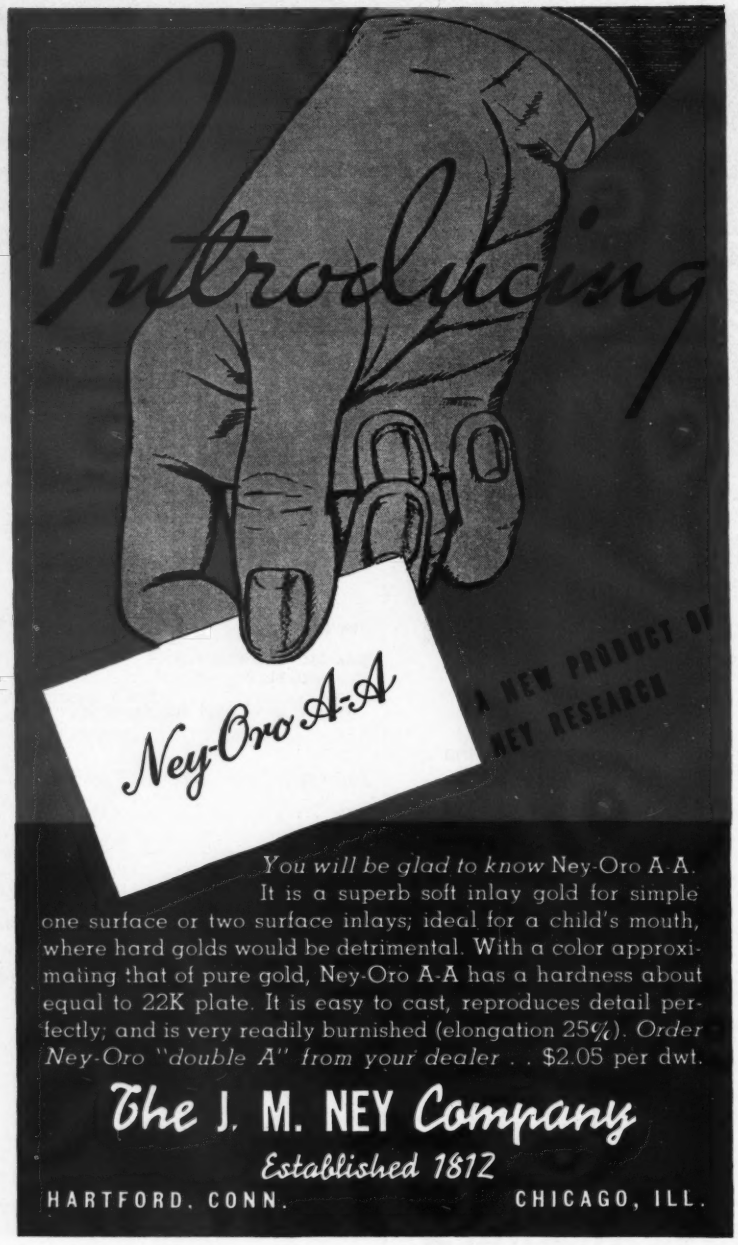

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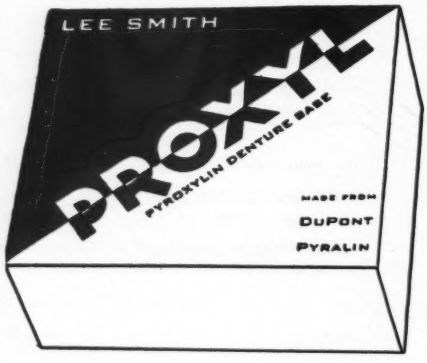

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(*Continued from page* 357)

felt the child was suffering from malnutrition rather than prematurity, and that liberal doses of vitamins CIO and AFL and the Farm Bureau concentrate would speed the infant's development.

Michael M. Davis, Ph. D., Chairman, Committee on Research in Medical Economics, predicts that all political parties would probably include health planks in their platforms.

Alice Hamilton, M.D., Consultant, U. S. Department of Labor, one of the foremost industrial hygienists, a contemporary of Julia Lathrop and Jane Addams, reminds the Conference that the federal government is not "an invading hostile power; it is ourselves and thus susceptible to our influences; so when we speak of the dangers of government and the terrors of paternalism, we are speaking about ourselves and the things that we have created and nurtured and are subject to our change."

The practical *Edwin E. Witte,* Ph.D., Professor of Economics, University of Wisconsin, who helped draft the Social Security Act, warns the Conference that enthusiasm, not necessity, led to legislation; that a great battle lies ahead; that the plan for a national health program would be called un-American legislation; and that the cost will be constantly emphasized to the people. He asks all supporters of the movement to unite and forget their differences of detail.

George Baehr, Chairman, Committee on Public Health Relations, New York Academy of Medicine, calls the coroner-physician system that infests most American communities an example of political patronage at its worst. If this system is to be followed in the appointment of personnel under the proposed plan, the whole activity, he cautions, will be doomed to failure.

As a result of this Conference and the one called by the Republican National Committee early in August an extensive national health program will doubtless be as issue in coming political campaigns. Furthermore, with the power of the farm and labor groups who have just begun to feel their potency there will be inaugurated an extensive health project regardless of the disapproval of the American Medical Association and associated professional groups.—*E. J. R.*